A. TYPE OF HANDBOOK

Part H, Division I, Mental Health and Alcohol and Other Drug Abuse (AODA) Services: Non-51.42 Board-Owned-and-Operated Clinics, is the service-specific portion of the Wisconsin Medical Assistance Provider Handbook. Part H, Division I, includes information for providers regarding provider eligibility criteria, recipient eligibility criteria, covered services, prior authorization procedures, and billing instructions. Part H, Division I is intended to be used in conjunction with Part A of the Wisconsin Medical Assistance Provider Handbook which includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the Wisconsin Medical Assistance Program (WMAP).

The information in Part H, Division I of the handbook applies only to providers who are certified as non-51.42 Board-operated outpatient psychotherapy or AODA clinics, or who are certified as psychiatrists or psychologists in private practice. WMAP- certified physicians may provide AODA services, but not psychotherapy, as specified in this handbook.

Hospitals providing mental health or AODA services through a hospital outpatient mental health or AODA clinic are subject to the policies and prior authorization procedures outlined in this handbook. However, the billing information does not apply to hospitals since they use a different claim form. As specified in HSS 107.08(3)(b)2. Wis. Admin. Code, outpatient services performed outside the hospital facility may not be reimbursed as hospital outpatient services. Therefore, clinics which are owned and operated by hospitals, but which are not located at the site of the hospital, must be separately certified as outpatient psychotherapy clinics. These clinics are subject to all the policies in this handbook. These clinics must bill services on the HCFA 1500 claim form.

Since HSS 105, Wis. Admin. Code, contains distinct certification requirements for separate programs, agencies providing other types of mental health programs (e.g., day treatment, Community Support Programs) are required to obtain separate WMAP certification for each of these programs. Providers may contact EDS for certification materials. Refer to Appendix 2 of Part A of the WMAP Provider Handbook for information on how to contact EDS. Separate DCS certification is required for each type of mental health program.

Providers who are also certified to provide other WMAP covered mental health/ AODA services should refer to the appropriate service-specific handbooks for information on those services. Part H, Division II, is for use by 51.42 Board-Operated Clinics providing mental health and AODA services. Part H, Division III, is for Mental Health Day Treatment providers. Part H, Division IV, is for AODA Day Treatment providers. Part H, Division V is for Community Support Program (CSP) providers.

Please note that the qualifications, definitions, and procedures for psychotherapy differ from AODA treatment and are separately described throughout this handbook.

B. PROVIDER INFORMATION

Eligibility for Certification of Psychotherapy Providers

Psychiatrists, psychologists, and all individuals providing services at non-Board-operated clinics must be individually certified by the WMAP. In order to be certified as a WMAP psychotherapy provider, one of the following requirements must be met:

- An outpatient psychotherapy clinic must be certified by the Division of Community Services (DCS) of the Department of Health and Social Services (DHSS) as meeting the outpatient psychotherapy clinic standards under HSS 61.91 to 61.98, Wis. Admin. code.

B. PROVIDER INFORMATION (continued)

- A psychiatrist must be a licensed physician under ch. 448, Wis. Stats., who has completed a residency in psychiatry.
- A psychologist must be licensed under ch. 455, Wis. Stats., and be listed or eligible to be listed in the National Register of Health Service Providers in Psychology. A psychologist licensed under ch. 455, Wis. Stats., with the academic credential of a doctoral degree who is not eligible for listing in the National Register, may be certified as a master's level provider.
- A master's degree psychotherapist must be employed by a WMAP-certified psychotherapy clinic and must meet the requirements listed in HSS 61.96 (1)(b) or (2), and HSS 61.96(3), Wis. Admin. Code.

Physician clinics and private physician groups must be certified as outpatient psychotherapy clinics in order to be reimbursed when a master's level psychotherapist is the performing provider.

Eligibility for Certification of AODA Treatment Providers

Physicians, psychologists, and all individuals providing services at non-board operated clinics must be individually certified by the WMAP. In order to be certified as a WMAP AODA treatment provider, one of the following requirements must be met:

- An outpatient AODA clinic must be certified by DCS as meeting the outpatient treatment program standards under HSS 61.59, Wis. Admin. Code.
- A physician must be licensed under ch. 448, Wis. Stats.
- A psychologist must be licensed under ch. 455, Wis. Stats., and be listed or eligible to be listed in the National Register of Health Service Providers in Psychology. A psychologist licensed under ch. 455, Wis. Stats., with the academic credential of a doctoral degree who is not eligible for listing in the National Register may be certified as a master's level provider.
- A master's degree psychotherapist must be employed by a WMAP-certified AODA clinic and meet the requirements listed in HSS 61.96(1)(b) or (2), and HSS 61.96 (3), Wis. Admin. Code.
- An alcohol and/or drug counselor must be employed by a WMAP-certified AODA clinic and must be certified by the Wisconsin Alcoholism Counselor Certification Board. An alcohol and/or drug counselor who is not certified by the Wisconsin Alcoholism Counselor Certification Board but has a development plan on file does not qualify for certification by the WMAP.

Physician clinics and private physician groups must be certified as outpatient AODA clinics in order to be reimbursed when a master's level psychotherapist or an AODA counselor is the performing provider.

Certification of Psychotherapy and AODA Treatment Providers

Providers are encouraged to apply for certification materials through EDS prior to the time of their DCS certification site visit in order to ensure the earliest possible certification effective date.

A provider meeting the eligibility requirements for psychotherapy or AODA treatment who wishes to be certified as a WMAP psychotherapy or AODA provider must contact:

B. PROVIDER INFORMATION (continued)

EDS
Attn: Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Providers other than physicians are required to submit a copy of the approval letter from DCS to verify that they have been certified to provide psychotherapy and/or AODA services in Wisconsin.

Scope of Service
The policies in Part H, Division I, govern services provided within the scope of practice as defined in HSS 107.13 (2) and (3), Wis. Admin. Code. Covered services and related limitations are listed in Section II of this handbook.

Reimbursement
Mental health and AODA providers in non-Board operated clinics are reimbursed at the lesser of the provider's usual and customary charge or the maximum allowable fee established by the DHSS. Copies of the Maximum Allowable Fee Schedule may be purchased by writing to EDS at the address listed in Appendix 38 of Part A of the WMAP Provider Handbook.

Providers are required to bill the WMAP their usual and customary charge for services provided, that charge being the amount charged by the provider for the same service when provided to private-pay patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Further information on billing is found in Section IV of this handbook.

Master's degree psychotherapists and AODA counselors are non-billing performing providers and may not be directly reimbursed for services they provide. Reimbursement for services performed by these providers may be made only to the certified clinic which employs them. Refer to Section IV-F of this handbook for billing instructions.

Provider Responsibilities
Specific responsibilities as a provider under the WMAP are stated in Section IV of Part A of the WMAP Provider Handbook. This section should be referenced for detailed information regarding fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

C. RECIPIENT INFORMATION

Eligibility For Medical Assistance
Recipients meeting eligibility criteria for the WMAP are issued Medical Assistance identification cards. The identification cards include the recipient's name, date of birth, 10-digit Medical Assistance identification number, medical status code, and when applicable, an indicator of health insurance coverage, managed care program coverage, and Medicare coverage.

Medical Assistance identification cards are sent to recipients monthly. All Medical Assistance identification cards are valid only through the end of the month for which they are issued. It is important that the provider or the designated agent check a recipient's Medical Assistance identification card prior to providing service to determine if the recipient is currently eligible and if there are any limitations to the recipient's coverage.

C. **RECIPIENT INFORMATION** (continued)

Section V of Part A of the WMAP Provider Handbook provides detailed information regarding eligibility for the WMAP, Medical Assistance identification cards, temporary cards, restricted cards, and how to verify eligibility. Review Section V of Part A carefully before services are rendered. A sample Medical Assistance identification card may be found in Appendix 7 of Part A of the WMAP Provider Handbook.

Medical Status

Medical Assistance recipients are classified into one of several eligibility categories, including qualified Medicare beneficiary-only (QMB-only). These categories allow for a differentiation of benefit coverage.

Additional information regarding medical categories may be found in Section V of Part A of the WMAP Provider Handbook.

Copayment

Except as noted below, all recipients are responsible for paying part of the costs involved in obtaining mental health and AODA services. The procedure codes and their applicable copayment amounts may be found in Appendix 15 of this handbook.

Providers are reminded of the following copayment exemptions:

- Emergency services
- Services provided to nursing home residents
- Services provided to recipients under 18 years of age
- Services provided to a pregnant woman if the services are related to the pregnancy
- Services covered by WMAP-contracted managed care programs to enrollees of the WMAP-contracted managed care program.

Copayment must be collected from the recipient by the provider of service. Applicable copayment amounts are automatically deducted by EDS from payments allowed by the WMAP. Do not reduce the billed amount of the claim by the amount of recipient copayment. Refer to Section IV of Part A of the WMAP Provider Handbook for further information on copayment.

Managed Care Program Coverage

WMAP recipients enrolled in WMAP-contracted managed care programs receive a yellow Medical Assistance identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. These codes are defined in Appendices 20, 21, and 22 of Part A of the WMAP Provider Handbook.

Providers must always check the recipient's current Medical Assistance identification card for managed care program coverage before providing services. Claims submitted to EDS for services covered by WMAP-contracted managed care program are denied.

WMAP-contracted managed care programs are required to cover all WMAP-covered mental health and AODA services. Further, managed care programs must guarantee that all Medical Assistance recipients enrolled in WMAP-contracted managed care programs have access to all medically necessary outpatient mental health and AODA services. No limit may be placed on the number of hours of outpatient treatment which the managed care program provides or reimburses when it is determined that treatment for mental or nervous disorders, alcohol or

C. **RECIPIENT INFORMATION** (continued)

drug abuse is medically necessary. Managed care programs may not establish any monetary limit or limit on the number of days of inpatient hospital treatment when it is determined that this treatment is medically necessary. Managed care programs may establish their own authorization procedures.

For recipients enrolled in a WMAP-contracted managed care program, all conditions of reimbursement and prior authorization for mental health and AODA services are established by the contract between the managed care programs and certified providers.

Additional information regarding managed care program noncovered services, emergency services, disenrollment, and hospitalizations is included in Section IX of Part A of the WMAP Provider Handbook.

Recipient Eligibility for Mental Health and Alcohol and other Drug Abuse Services
As specified in HSS 107.03(15), Wis. Admin. Code, the following recipients are not eligible for services through the WMAP:

- an individual who is currently in jail or a correctional facility; and
- an individual 21 to 64 year of ages who is a resident of an institution for mental disease (IMD), unless the recipient is 21 years of age, was a resident of the IMD immediately prior to turning 21 and has been continuously a resident since then, unless the individual is on convalescent leave. (If these conditions are met, treatment may be provided up to the recipient's 22nd birthday.) "Convalescent leave" means a resident's temporary release from an IMD to residency in a community setting, not more frequently than once a year and beginning on the fourth day after release. The trial period of residence in the community must last at least four days but no longer than 30 days, or until the recipient is permanently discharged from the IMD, whichever occurs first.

Any WMAP payments made on these claims must be returned to the WMAP. Medicare claims for coinsurance/deductible are not reimbursable by the WMAP for recipients in an IMD.